State of New Mexico
Employee Supplemental Life and Dependent Life

EMPLOYEE INFORMATION				
1.SSN / ITIN	2. Employee (Last, First, M.I.)	3. Date of Birth	4. Sex ☐ M ☐ F	5. Marital Status ☐ Married ☐ Single

6. Mailing Address	7. City	8. County of physical residence	9. State	10. Zip

11. Home Phone	12. Work Phone	13. Cell Phone	14. Preferred Phone	15. Email Address	16. Employee ID

17. Entity Code	18. Entity Name	19. Effective Coverage	20. Reason for Change

LIFE INSURANCE SUPPLEMENTAL COVERAGE

Coverage Type	Minimum	Maximum	Guaranteed Issue (GI)
Basic Life Insurance Coverage $50,000-Paid by Employer			
Coverage Options - Increments of $10,000.00			
Employee Supplemental	$10,000.00	$500,000.00	$150,000.00
Dependent Spouse/Domestic Partner (DP)	$10,000.00	$250,000.00	$30,000.00
Coverage Options - Increments of $5,000.00			
Dependent Child/ren	$5,000.00	$15,000.00	$15,000.00

All inquiries shall be made to Erisa Administrative Services, Inc.

Toll Free: 855-618-1800 E-Mail: sonm@easitpa.com

Indicate with an A (add), D (drop), C (continue coverage) and W (waived coverage) for all names listed below.

Relationship Codes: 1=Employee, 2=Spouse, 3=Son, 4=Daughter, 5=Domestic Partner, 6 =Domestic Partner Child

Life	Coverage	Social Security No.	Name (Last Name, First Name, MI)	Sex M or F	Rel. Code 1- 6	Date of Birth
		Employee				
		Spouse/Domestic Partner				
		Dependent				
		Dependent				
		Dependent				
		Dependent				
		Dependent				
		Dependent				

I hereby authorize and direct my employer to reduce my salary in the amount elected for Supplemental and/or Dependent Life Insurance.

I understand once I elect Supplemental Life Insurance coverage it may be modified at any time. However, I acknowledge that the guaranteed issue (GI) amount may not be available outside the 2019 Special Open Enrollment Period.

I understand that the effective date for State will be the first date of the pay period following the date of enrollment. For LPB's the effective date will be the first date of the month following the date of enrollment.

I understand it is my responsibility to complete the beneficiary designation form to include a primary beneficiary (ies) as well as a contingent beneficiary.

I understand it is my responsibility to confirm the cost is deducted for the elected coverage from my paycheck each pay period.

State Employees- I understand if I am on leave and want to participate in the Term Life Special Enrollment, my effective date will be delayed until the first day of the pay period following return to work. For LPB Employees- My effective date will be the first day of the month following return to work.

I understand my responsibility to review my pay advice and confirm my elected coverage premiums are correctly deducted. I further understand that, due to multiple systems and rounding practices, the total amounts may differ by $.01 each month (approximately $.12 per year).

I understand I must print this enrollment form, submit a copy to my HR Administrator, and keep a copy for my personal records.

Submission Date

READ BEFORE PROCEEDING

THE HARTFORD

BENEFICIARY DESIGNATION INSTRUCTIONS

Effective: July 1, 2019

Policy#681601

As a member of the recently awarded life administrator, The Hartford, please designate your primary beneficiary as well as a contingent beneficiary; if applicable.

What is a contingent beneficiary? A contingent beneficiary is a beneficiary utilized in the event the primary designated beneficiary is deceased, unable to be located, or refuses inheritance at the time benefits are to be paid. The named contingent beneficiary will receive and is entitled to your benefit.

Important:

- If you wish to designate separate beneficiaries for Basic Life insurance and Supplemental Life insurance, it is required to identify on the beneficiary designation form and complete one for each plan type. Indicate on the Beneficiary Designation form the line of coverage.

  Example:

  First Beneficiary Form – $50K Basic Life

PRIMARY BENEFICIARY(IES)

Name: Spouse Name | Date of Birth: 08/12/2019

Address: 1234 Main St. Santa Fe, NM 87500 | Telephone Number: (505) 000-0000

Social Security Number: 000-00-0000 | Relationship: Spouse | Benefit Percent: 100 %

  Second Beneficiary Form – Supplemental Life

PRIMARY BENEFICIARY(IES)

Name: Child Name | Date of Birth: 08/12/2019

Address: 1234 Main St. Santa Fe, NM 87500 | Telephone Number: (505) 000-0000

Social Security Number: 000-00-0000 | Relationship: Child | Benefit Percent: 50 %

PRIMARY BENEFICIARY(IES)

Name: Child Name | Date of Birth: 08/12/2019

Address: 1234 Main St. Santa Fe, NM 87500 | Telephone Number: (505) 000-0000

Social Security Number: 000-00-0000 | Relationship: Child | Benefit Percent: 50 %

Concluding Directions:

- Submit original Beneficiary Designation form(s) to the Agency Human Resource Administrator.
- Keep a copy for your personal records.
- Fax a copy to Erisa 505-244-6009

BENEFICIARY DESIGNATION FORM INSTRUCTIONS

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group/employer.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. The listed percentages must add up to 100%. Please provide all of the information requested. If your beneficiary is not related either by blood or by marriage, insert the words, “Not Related” as their stated relationship. If you need assistance, contact your Company’s benefits administrator or your own legal advisor.

A beneficiary for employee Life Insurance may be changed at any time upon written request.

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA).

Sample wording for common beneficiary designations are shown below:

Example #1:

Jane Doe	Relationship: Spouse	Benefit Percentage: 100%

Example #2:

Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Susan Doe	Relationship: Daughter	Benefit Percentage: 25%
John Doe	Relationship: Son	Benefit Percentage: 25%

If additional space is required, write, “See attached”, on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Employee) and dated.**

BENEFICIARY DESIGNATION

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) *(check only one box),* I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name:	Employee ID Number:	Social Security Number: X X X X X ☐ ☐ ☐ ☐
Employee Address:		Telephone Number:
Policyholder/Employer:		Policy Number:

NAMING YOUR GROUP LIFE BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact your Company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to you if living, otherwise, the insurer, at their option, may pay the benefit to your surviving spouse or to the executors or administrators of your estate.

PRIMARY BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

CONTINGENT BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Disclaimer: Spousal consent does not apply to ERISA plans.

Spousal Consent For Community Property States Only: If you live in a community property state - Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, or Wisconsin - you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ **Date:** _____

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Employee: _____ **Date:** _____

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA)